

Request for Service Credit Cost Information — Leave of Absence

888 CalPERS (or 888-225-7377) • TTY: For Speech & Hearing Impaired (916) 795-3240

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	Name of Member (Last Name, First Name, Middle Initial)			Social Security N	Social Security Number	
Section 1	About You					
	Have you requested this cost information before? ☐ No ☐ Yes					
	Have you submitted a retirement application? \(\Pi \) No \(\Pi \)					
	Retirement Date (mm/dd/yyyy)					
	Former Name (if applicable)	Current Emp	loyer			
	Mailing Address					
	 City	State	ZIP Code	Daytime Phone		
Section 2	Employment Information					
	Linployment information					
ist the name and address of the employer that	Employer					
granted the leave.	Address					
List the dates and type				1	1	
of leave for each period	City			State	ZIP Code	
requested.		Type/Purpos	e of Leave			
Types of Leave	Dates of Leave From (min/dd/yyyy) To (min/dd/yyyy)	Type/Fulpos	e oi Leave			
Maternity/Paternity,	Dates of Leave From (mm/dd/yyyy) To (mm/dd/yyyy)	Type/Purpos	e of Leave			
Temporary Disability,		ſ				
Educational, Service,	Dates of Leave From (mm/dd/yyyy) To (mm/dd/yyyy)	Type/Purpos	e of Leave			
Sabbatical, Employee's Own Serious Illness						
OWII Sellous IIIIless	Dates of Leave From (mm/dd/yyyy) To (mm/dd/yyyy)	Type/Purpos	e of Leave			
Section 3	Certification					
Give the form to the						
employer that granted the	Member Signature			Date (mm/dd/yyy	/y)	
leave to complete						
Section 4 (and to route						
to the compensation carrier to complete						
Sections 5 and 6).						
Section 4	Leave of Absence Certification (to be com	pleted by em	ıployer)			
Employer: Return the		1				
completed form to	Dates of Leave From (mm/dd/yyyy) To (mm/dd/yyyy)	Type/Purpos	e of Leave			
the member or forward	I hereby certify that the above information is true and correct. If leave was for Serious Illness, I further certify					
it to the employee's	that the period was an uncompensated leave of abser	nce approved	for the employ	ree's own serious	illness.	
Workers' Compensation						
carrier, as appropriate.	Employer Signature	Title		Date (mm/dd/yyy	y)	
	Printed Name	Davtime Pho	ne	FAX		

Put your name and Social Security number at the top of every page.	Name of Member (Last Name, Fi	irst Name, Middle Initial)	Social Security Number			
Section 5	Temporary Disabi	lity Leave of Absence Certification				
To be completed by the Workers' Compensation carrier	Workers' Compensation					
that provides temporary	Name of Employer's Disability C	arrier				
disability benefits.	Carrier's Address		Carrier's Phone Number			
* If there was more than	Employee's Claim Number*	Beginning Date of Temporary Disability Payments (mm/dd/yyyy)	Ending Date of Payments (mm/dd/yyyy			
one temporary disability						
leave period, provide claim	Effective Date of Permanent Disability Rating*					
numbers and dates for each.	Was there a settlement by Compromise and Release? ☐ No ☐ Yes. Provide copy.					
Section 6	Signature of Author	orized Workers' Compensation Carrier R	epresentative			
Please return this request form to the member.	I hereby certify that the above information is true and correct.					
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	Carrier Signature		Date (mm/dd/yyyy)			
	1	1				
	Printed Name	Title				

Mail to: